General

Guideline Title

Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement.

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med. 2011 Apr 5;154(7):483-6. PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for testicular cancer: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 2 p. [3 references]

Recommendations

Major Recommendations

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the levels of certainty regarding net benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendation and Evidence

The USPSTF recommends against screening for testicular cancer in adolescent or adult males. This is a grade D recommendation.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to asymptomatic adolescent or adult males. The USPSTF did not review the evidence for screening males with a history of cryptorchidism.

Screening Tests

The sensitivity, specificity, and positive predictive value of testicular examination in asymptomatic patients are unknown. Screening examinations performed by patients or clinicians are unlikely to provide meaningful health benefits because of the low incidence and high survival rate of testicular cancer, even when it is detected at symptomatic stages.

Treatment

Management of testicular cancer consists of orchiectomy and may include other surgery, radiation therapy, and chemotherapy, depending on the disease stage and tumor type. Regardless of disease stage, more than 90% of all newly diagnosed cases of testicular cancer will be cured.

Useful Resources

The National Cancer Institute's Physician Data Query, available at www.cancer.gov/cancertopics/pdq, is a comprehensive database that contains summaries on a wide range of cancer-related topics for health professionals and patients, including testicular cancer screening and treatment.

Definitions:

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If this service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence

Level of Certainty	Description
	As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Testicular cancer

Guideline Category

Prevention

Screening

Clinical Specialty

Family Practice

Internal Medicine

Oncology

Pediatrics

Preventive Medicine

Urology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on screening for testicular cancer and the supporting scientific evidence
- To reaffirm the 2004 recommendations on screening for testicular cancer

Target Population

Adolescent and adult males

Interventions and Practices Considered

Screening for testicular cancer with clinical examination or patient self-examination

Major Outcomes Considered

Key Question 1: What are the benefits of screening asymptomatic men for testicular cancer?

Key Question 2: What are the harms of screening asymptomatic men for testicular cancer?

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by Agency for Healthcare Research and Quality (AHRQ) staff for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources and Searches

AHRQ staff members searched the English-language literature for studies on the benefits and harms of testicular cancer screening in asymptomatic men that were published between 1 January 2001 (the last year searched by the previous USPSTF review) and 11 November 2009, using the search terms *testicular neoplasm with germinoma* and *mass screening* or *screening*. The initial search was restricted to articles indexed in the Cochrane Database of Systematic Reviews and the PubMed core clinical journal subset (previously known as the Abridged Index Medicus). When the initial search yielded few articles, searches were expanded to include noncore journals. These searches were supplemented by reviewing reference lists of recent reviews and clinical guidelines.

Study Selection

To determine the benefits of screening, AHRQ staff included randomized, controlled trials; meta-analyses; systematic reviews; cohort studies; and case–control studies. To determine the harms of screening, they included randomized, controlled trials; meta-analyses; systematic reviews; cohort studies; case–control studies; and case series of large, multisite databases. Case reports, narrative reviews, editorials, and practice guidelines were excluded.

Articles were evaluated at the title, abstract, and full-text stage by using predetermined exclusion criteria. Articles selected for further examination by at least 1 author advanced to the next stage of review. At the full-text article stage, differences of opinion were resolved by consensus.

Number of Source Documents

A total of 113 articles were retrieved and entered into a reference EndNote (Thomson Reuters, New York, New York) database. After sequential review of the titles, abstracts, and full text, it was determined that none of the articles met all of the inclusion criteria. The most common reason for exclusion was that the testing or interventions were performed in symptomatic populations. Therefore, the 3 articles that reached the full-text review stage were discussed.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by Agency for Healthcare Research and Quality (AHRQ) staff for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction

One author abstracted information on study design, sample size, entry criteria, and other outcomes of interest.

Data Synthesis and Analysis

Data were described and synthesized in a narrative format.

Methods Used to Formulate the Recommendations

Balance Sheets

Expert Consensus

Description of Methods Used to Formulate the Recommendations

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D

Moderate Certainty of Net Benefit	B Magnitude of Net Benefit	B	C	D
Low	Insufficient Substantial	Moderate	Small	Zero/Negative

**A, B, C, D,* and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the USPSTF seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the USPSTF considers indirect evidence. To guide its selection of indirect evidence, the USPSTF constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the USPSTF's overall assessment of evidence was described as good, fair, or poor. The USPSTF realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the USPSTF's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the USPSTF makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The USPSTF must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The USPSTF considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the USPSTF assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The USPSTF would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The USPSTF would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the USPSTF to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875.[5 references].

Rating Scheme for the Strength of the Recommendations

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I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If this service is offered, patients should understand the uncertainty about the balance of benefits and harms.

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Level of Certainty	Description
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Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods

Level of Certainty	Description
	• Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these external comments before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and federal agencies. These comments are discussed before final recommendations are confirmed.

Response to Public Comments. A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from 21 September through 19 October 2010. Some comments requested clarification about whether the USPSTF's definition of *screening* includes patient self-examination in addition to clinician examination. Other comments expressed concern that this statement might discourage patients with testicular symptoms from seeking appropriate care. In response, the USPSTF revised the Clinical Considerations section to address these issues.

Recommendations of Others. Recommendations regarding screening for testicular cancer were considered from the following groups: the American Academy of Family Physicians, the American Academy of Pediatrics and the American Cancer Society.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Benefits of Detection and Early Intervention

Based on the low incidence of this condition and favorable outcomes of treatment, even in cases of advanced disease, there is adequate evidence

that the benefits of screening for testicular cancer are small to none.

Potential Harms

Harms of Detection and Early Intervention

Potential harms associated with screening for testicular cancer include false-positive results, anxiety, and harms from diagnostic tests or procedures. The U.S. Preventive Services Task Force (USPSTF) found no new evidence on potential harms of screening and concluded that these harms are no greater than small.

Qualifying Statements

Qualifying Statements

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policymakers should understand the evidence but individualize decision making to the specific patient or situation.

Implementation of the Guideline

Description of Implementation Strategy

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the USPSTF will make all its products available through its Web site . The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

Implementation Tools

Foreign Language Translations

Mobile Device Resources

Patient Resources

Pocket Guide/Reference Cards

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

U.S. Preventive Services Task Force. Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med. 2011 Apr 5;154(7):483-6. PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2011 Apr 5)

Guideline Developer(s)

U.S. Preventive Services Task Force - Independent Expert Panel

Guideline Developer Comment

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

Source(s) of Funding

United States Government

Guideline Committee

U.S. Preventive Services Task Force (USPSTF)

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**Member of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to http://www.uspreventiveservicestaskforce.org/Page/Name/our-members*.

Financial Disclosures/Conflicts of Interest

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. USPSTF members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for testicular cancer: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 2 p. [3 references]

Guideline Availability

Electronic copies: Available from the Annals of Internal Medicine Web site.

Availability of Companion Documents

The following are available:

Evidence Reviews:

- Lin K, Sharangpani R. Screening for testicular cancer: an evidence review for the U.S. Preventive Services Task Force. Ann Intern Med. 2010;153:396-399. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Barton MB et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med 2007;147:117-122.
- Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med 2007;147:871-875.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site .

The following are also available:

- Screening for testicular cancer: clinical summary of a U.S. Preventive Services Task Force recommendation. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2011. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site .
- The guide to clinical preventive services, 2010-2011. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2010. 292 p. Electronic copies: Available from the AHRQ Web site .

The Electronic Preventive Services Selector (ePSS) , available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

Patient Resources

The following are available:

- Screening for testicular cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement. Summaries for patients. 2010. Available from the Annals of Internal Medicine Web site .
- Men: stay healthy at any age. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 10-IP004-A. 2010 Aug. 2 p. Electronic copies: Available in Portable Document Format (PDF) in English and Spanish from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site .

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/research/publications/index.html or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on April 8, 2004. The updated information was verified by the guideline developer on April 22, 2004. This

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